Person-Centered Aftercare Planning for People Transitioning from Chronic Homelessness Into Housing:

Lessons Learned from the Beyond Housing Care Conference Table

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Beyond Housing Origins

Social Psychiatry and Psychiatric Epidemiology
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ORIGINAL PAPER

Multi-trajectory group profiles of well-being and associated predictors among adults experiencing homelessness and mental illness: findings from the At Home/Chez Soi study, Toronto site

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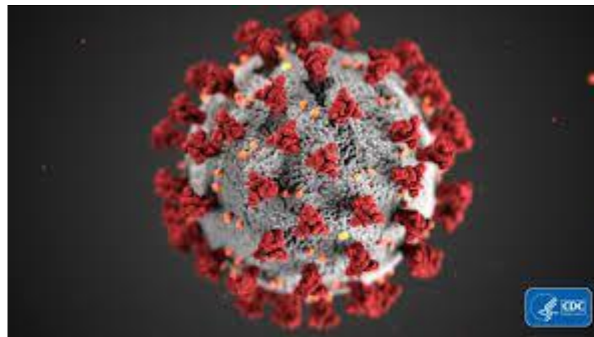
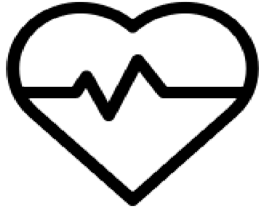
Abstract



Beyond Housing: Three-Part Pilot



Develop wellbeing and trauma-focused holistic services

Create Service Coordination Table

Increase long term, open ended case management

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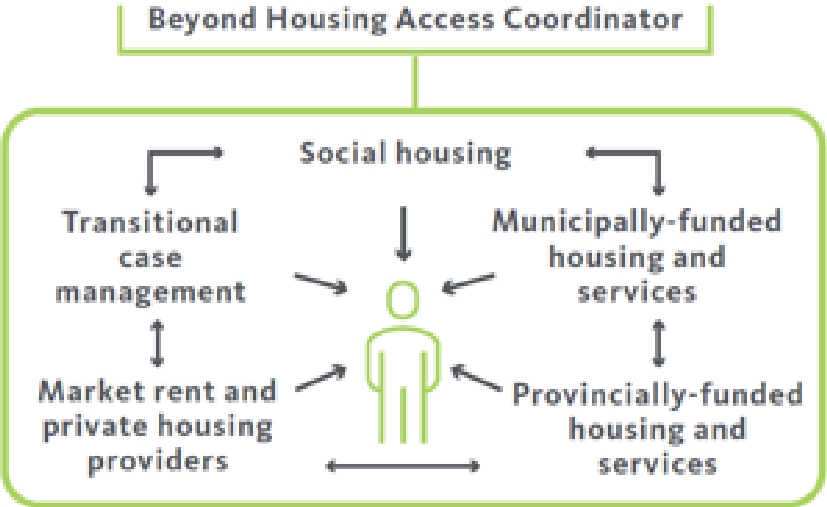
Care Conference Table



Care Conference Process & Coordinated Access

<table>
<tr><th>Access</th><th>Assessment</th><th>Prioritization</th><th>Matching & Referral</th></tr>
<tr>
<td>Eligibility: Follows City’s prioritization criteria, along with the below

Client Identification

1. “List-based”: Identifying residents on the City’s By-Name List who are eligible for housing opportunities, but are not engaging with housing workers.

2. “Referral-based”: Identifying residents based upon staff recommendation.</td>
<td>1. STARS Tool

2. Huddle: Bringing people together who are currently working with the resident to gain a comprehensive understanding of the resident.</td>
<td>City’s Prioritization Criteria

- Chronic homelessness
- Indigenous community members
- Young people
- Seniors
- Black people
- Other racialized people
- 2SLGBTQ+ people
- Women</td>
<td>1. Pre-Housing Care Conference Table (CCT): Huddle participants and community-based service providers come together. Resident bio and goals presented. Clients can be brought back multiple times.

2. Care Plan: Based upon CCT, care plan developed.

3. Post-Huddle: Role identification and “being kept in the loop”

4. Summit: Client meeting with Circle of Care.

5. Post-Housing Care Conference Table: Shifting focus to housing stabilization.</td>
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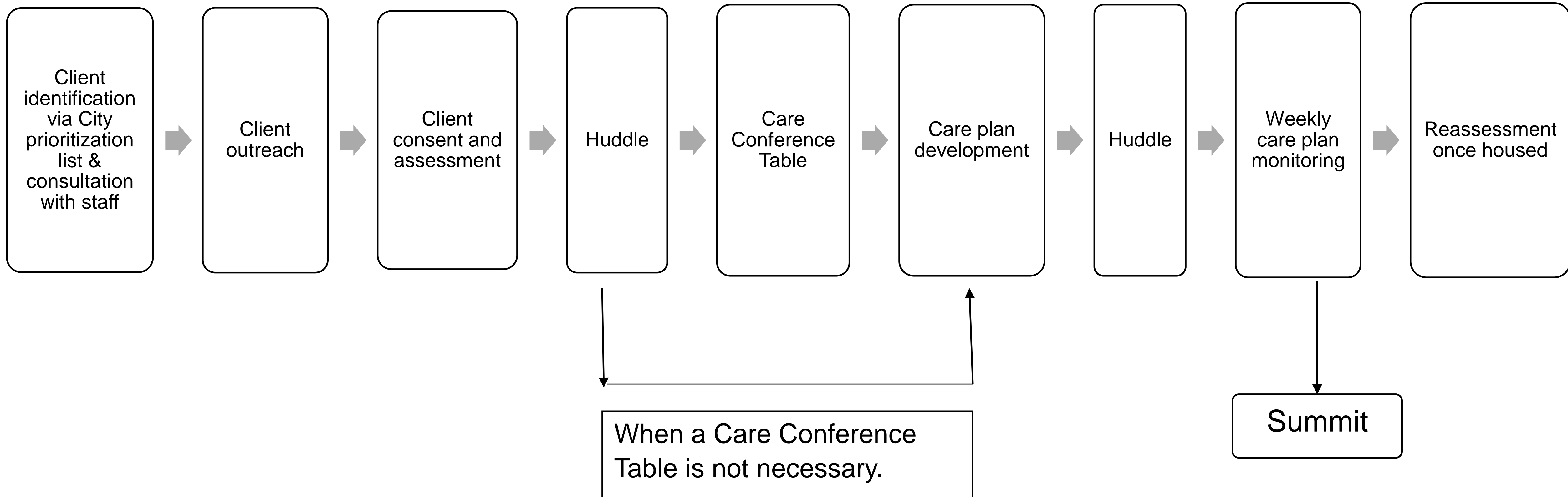
Process Map



Why So Many Steps?!?!?!

- **Assessment** is **only one step** of the process!
- **Client-centered** approach moving at the **pace** of who we work with.
- Clients may not go through all steps.

  - **Huddles**: Information gathering.
  - **Care Conference Table**: Brainstorming.
  - **Care Conference Table Revisits**: Problem solving.
  - **Summits**: Circle of care with client present.

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What Happens if a Client Moves Locations?

- Unique value add of **service coordination**.
- The outlined processes support client continuum of care by:
  - **Keeping track of clients** when moving to a new provider.
  - **Fostering collaboration** with new providers.
  - **Not losing momentum** with housing goals.
  - **Identifying new challenges and needs** that may emerge in a new setting.

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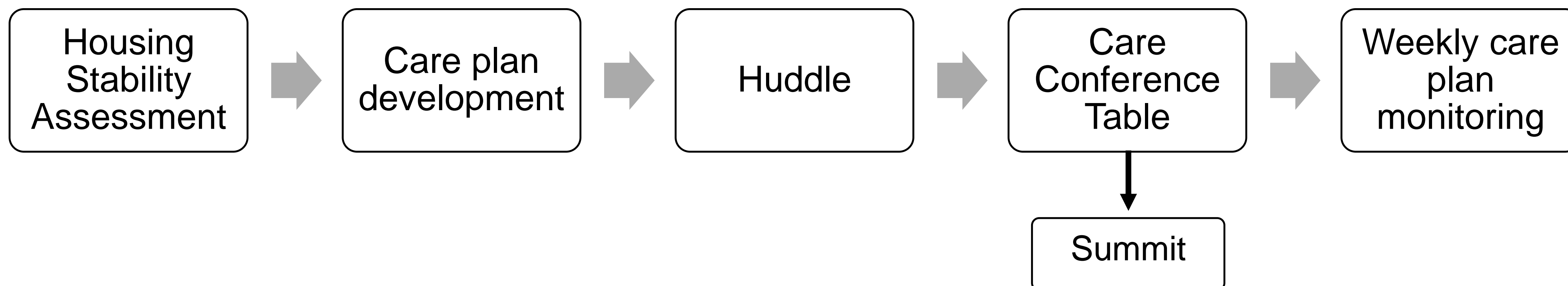
What Happens Once a Client Attains Housing?

- Shifts to housing stabilization and community integration. Continued focus on wellness.
- Process is unique to each client – Nothing is linear! Client's care plan is never complete. Living document.



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Challenges

- **Coordinating** with various service organizations.
- **Impact of poverty** as it relates to food security, community engagement activities.
- **Finding alternative housing opportunities** when there is not a good fit.
- **Being nimble** to address rapidly changing circumstances (e.g., shelter hotel closures).
- **Socio-political context** (e.g., pandemic, austerity, affordable housing crisis)

Early Learnings & Key Takeaways

- Importance of **transparency** and keeping people **in the loop** (with client consent).

- System coordination is challenging work not because of people, but because of **technological limitations** (e.g., multiple databases)
  - Case managers are able to follow clients but the system notes do not.

- Shifting from **“my” client to “our” client** mindsets leads to creative strategies for people who are typically unengaged.

- Opportunity of Coordinated Access to **support clients once they are in housing**! Continue the work past the “Matching & Referral” stage.

Thank You!

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